GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

www.GIMEDRI.com

Name_____**Date of Birth**_____

Gastrointestinal Medicine Associates, Inc.
Medical History

Asthma / COPD	O Yes	O No	Obstructive Sleep Apnea	O Yes	O No
Diverticulitis	O Yes	O No	Crohn's Disease / Ulcerative Colitis	O Yes	O No
High Blood Pressure	O Yes	O No	Celiac Disease	O Yes	O No
High Cholesterol	O Yes	O No	Barrett's Esophagus	O Yes	O No
Heart disease	O Yes	O No	Peptic ulcer disease	O Yes	O No
Diabetes Mellitus	O Yes	O No	Pancreatitis	O Yes	O No
Irritable Bowel Syndrome	O Yes	O No	Ulcerative colitis	O Yes	O No
Inflammatory Bowel Disease/Colitis	O Yes	O No	Gall stones	O Yes	O No
Personal History of Colon cancer	O Yes	O No	Anemia	O Yes	O No
Personal History of Colon polyp	O Yes	O No	GERD/Reflux	O Yes	O No
Liver disease	O Yes	O No	Hemorrhoids	O Yes	O No
If Yes, what condition(s)?_____ _____			Family History of colon cancer	O Yes	O No
			Family History of Colon polyp	O Yes	O No
Have you ever been diagnosed with H.Pylori?	O Yes	O No			
Do you have a Cardiac Defibrillator or Pacemaker?	O Yes	O No			

Do you have any other chronic medical conditions: _____
_____
_____
_____

Have you had your flu shot since the most recent September 1st?_____

If you are 65 or older, have you had your pneumonia vaccine yet? _____

OVER ➡

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Social History

Marijuana Use (in any form)	O Yes	O No
Travel (outside the USA)	O Yes	O No
Tattoos	O Yes	O No
Cocaine	O Yes	O No
IV Drugs	O Yes	O No
Caffeine	O Yes	O No

Smoking O Yes O No packs/day_____how long_____quit____

Alcohol O Yes O No drinks/day_____drinks/week_____

Family History

Mother O Alive O Deceased Age_____

O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease

O Other_____

Father O Alive O Deceased Age_____

O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease

O Other_____

Siblings O Alive O Deceased Age_____

O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease

O Other_____

Children O Alive O Deceased Age_____

O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease

O Other_____

Surgical History-Please list all surgeries, including Colonoscopy, Metal Implants

_____

_____

Medication List

Do you take:

Aspirin	O Yes	O No
Over the counter pain medication	O Yes	O No
Diabetes medication	O Yes	O No
Plavix, Coumadin, or other blood thinner	O Yes	O No

ALLERGIES: _____

Signature:_____**Date:**_____